



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

THOMAS L FREYTAG ATTY  
PLAZA DAY SURGERY CENTER  
PO BOX 600124  
DALLAS TX 75360

#### **Respondent Name**

AMERICAN HOME ASSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-05-A319-01

#### **MFDR Date Received**

JULY 11, 2005

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Plaza Day Surgery Center disputes the carrier's payment on this claim since the carrier did not adhere to the network contract that my client has with First Health for reimbursement of ambulatory surgical services provided to Claimant by Requesting Party. Requesting Party billed its usual and customary charges of \$11,792.04 for these services..." "Carrier reimbursed Requesting Party \$1,118.00 for these medical services..." "Clearly the 'fair and reasonable' reimbursement for the medical services charges in this matter is best established by the agreed reimbursement the carrier has contractually agreed to pay for the medical services provided to Claimant." "...under the terms of the Contract Requesting Party is reimbursed at 57% of Requesting Party's usual and customary charges."

**Amount in Dispute:** \$5,603.46

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "It is the Respondents position that the Requestor was paid more than a fair and reasonable amount as determined in accordance with the criteria for payment under the ACT. Specifically, the amount paid by the Respondent was more than that which would be allowed under Medicare. Respondent has paid Requestor \$1118.00 which is the same amount that a full service hospital would be paid for its facility charges associated with a spinal surgery and a one-day inpatient hospitalization. Such billing is utterly excessive and violates the cost containment policies of the Act and the Division"

**Response Submitted by:** The Hartford

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 30, 2004	ASC Services for CPT Code 29846	\$1,509.70	\$0.00
	ASC Services for CPT Code 64721-59	\$1,276.23	\$0.00
	ASC Services for CPT Code 20926-59	\$2,282.85	\$0.00
	ASC Services for CPT Code 99070	\$534.68	\$0.00

TOTAL		\$5,603.46	\$0.00
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## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason code:
  - M-In Texas, outpatient services are to be paid as fair and reasonable.

### **Findings**

1. This dispute relates to ambulatory surgical services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. Former 28 Texas Administrative Code §133.307(g)(3)(E), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that "Prior to submission, any documentation that contains confidential information regarding a person other than the injured employee for that claim or a party in the dispute must be redacted by the party submitting the documentation, to protect the confidential information and the privacy of the individual. Un-redacted information or evidence shall not be considered in resolving the medical fee dispute." Review of the submitted information finds that the requestor has submitted un-redacted confidential information regarding a person other than the claimant that has not been redacted. The Division concludes that this documentation does not meet the requirements of §133.307(g)(3)(E). The unredacted information will not be considered in this review.
4. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
  - The requestor's position summary states that "Plaza Day Surgery Center disputes the carrier's payment on this claim since the carrier did not adhere to the network contract that my client has with First Health for reimbursement of ambulatory surgical services provided to Claimant by Requesting Party. Requesting Party billed its usual and customary charges of \$11,792.04 for these services..." "Carrier reimbursed Requesting Party \$1,118.00 for these medical services..." "Clearly the 'fair and reasonable' reimbursement for the medical services charges in this matter is best established by the agreed reimbursement the carrier has contractually agreed to pay for the medical services provided to Claimant." "...under the terms of the Contract Requesting Party is reimbursed at 57% of Requesting Party's usual and customary charges..."
  - The requestor did not submit a copy of the contract or other documentation to support that the provider is reimbursed at 57% of requestor's usual and customary charges for the services in dispute.
  - The requestor does not discuss or explain how payment of 57% of usual and customary charges would result in a fair and reasonable reimbursement.
  - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
  - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:  
 "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
- In support of the requested reimbursement, the requestor submitted un-redacted EOBs for services that are similar to the services in dispute. Per Division rule at 28 TAC §133.307(g)(3)(E), "Un-redacted information or evidence shall not be considered in resolving the medical fee dispute." Therefore, the un-redacted EOBs were not considered in this decision.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	04/26/2013 Date
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### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**